ADDENDUM A - REVISED 7-1-10

(LOCAL GOVERNMENT GROUPS) 1 of 2 Pages

Notification of COBRA Rights and Requirements

Coverage may continue in certain instances where coverage under the Plan would normally end. The information below advises you of your rights and obligations under this continuation coverage, made possible under federal legislation commonly referred to as COBRA. A person who is eligible for continuation is called a “qualified beneficiary.” Each qualified beneficiary, or the parent or legal guardian of a minor qualified beneficiary, has a right to make a separate election for a qualified beneficiary or for such minor. The events making a person eligible are called “qualifying events.” Questions may be directed to the plan administrator. This notice does not fully describe your rights under this continuation coverage and the Plan and a more complete description regarding such rights is available in the Plan’s summary plan description booklet or from the Plan administrator.

Eligibility for Continuation The following qualifying events make a plan participant eligible as a qualified beneficiary. If an employee’s medical coverage terminates because of termination of employment (other than for gross misconduct) or reduction of hours, the employee is a qualified beneficiary and may elect to continue the medical coverage. If you are a spouse/dependent of an employee, and were covered under the Plan at the time of the qualifying event, or born of the employee or adopted by the employee during the period of COBRA continuation and qualify as a “dependent” under the Plan, you have the right to continuation coverage if medical coverage terminated for any of the following events: (1) Death of an employee (2) Termination of the employee’s employment (other than for gross misconduct) or reduction in hours worked (3) Divorce or legal separation (4) Employee becomes covered under Medicare (5) Dependent child no longer meets the definition of an eligible dependent under the Plan (6) Substantial reduction in retiree coverage due to employer bankruptcy reorganization.

Notice of Qualifying Event/Election Period The plan sponsor will provide notice of the availability of continuation coverage when the following qualifying events occur: (1) Employee’s death (2) Loss of coverage due to employee’s termination of employment (other than for gross misconduct) or reduction of work hours (3) Loss of coverage due to Medicare entitlement (4) Substantial reduction in retiree coverage due to employer bankruptcy reorganization. Plan participants must notify the plan sponsor in writing within 60 days of a divorce, separation, child losing dependent status in order to arrange for continuation coverage. The plan administrator will then provide the plan participants an election notice. An election for continuation coverage must be made within the 60-day election period beginning on the later of the date the coverage would end because of one of the qualifying events described above or the date the participant(s) is sent COBRA notice. In order for the plan administrator to notify you of your COBRA rights, it is important for you to keep the plan administrator advised of your current address.

Period of Continuation Continuation will terminate on the earliest of the following dates: (I) The end of: (a) 18 months, in the case where the coverage ended because of termination of employment (other than for gross misconduct) or reduction of hours (b) 36 months total, for dependents of the plan participant who have other including second qualifying events (c) 29 months, for employees and dependents if either the employee or a qualified dependent beneficiary is classified as disabled under the terms Title II or XVI of the Social Security Act within 60 days of the time of termination of employment or reduction of hours provided you notify the Plan Sponsor in writing within 60 days after you receive notice of disability from the Social Security Administration, and providing that you provide such notice to the Plan Sponsor before the end of the initial 18 months of COBRA continuation. (2) The date after the COBRA election on which the person first becomes: a) covered under any other group health plan, as an employee or otherwise. (NOTE: Qualified beneficiaries, i.e., employee, spouse and/or dependents, who become covered by another group insurance program, are allowed to continue COBRA coverage only if the other group insurance plan has a pre-existing condition limitation or exclusion clause that applies to that individual’s coverage. COBRA coverage will continue only to the time period specified above, or if earlier, when the preexisting conditions restriction no longer applies) (b) entitled to benefits under Medicare (3) The date the premium is not paid (4) The date the plan sponsor no longer provides group health coverage to any of its employees (5) In the case where continuation of coverage is extended to 29 months, this extended coverage will be terminated the first day of the month following 30 days after the final determination that the individual is no longer disabled. You are required to notify the plan sponsor within 30 days of any event described above which would cause COBRA coverage to end.

Election and Premium Payment If continuation coverage is chosen, this coverage will be identical to the coverage provided under the plan prior to the qualifying event. Qualified beneficiaries choosing to continue coverage under COBRA must pay the entire premium amount (plus a 2% administration charge, or plus 50% during an 11 month disability extension) to the plan sponsor on a monthly basis. (Monthly premium rates are subject to change annually). Payroll deduction is not available to COBRA participants. Checks should be made payable to the plan sponsor. The qualified beneficiary’s first payment deadline is 45 days after the date of their continuation election. The subsequent payment due date is the first day of the month for which coverage is purchased with a deadline of 30 days after the due date. Failure to pay premiums by these deadlines will result in termination of coverage. Information on current premiums is available by contacting the plan sponsor. Failure to elect COBRA coverage may cause you to avoid having pre-existing conditions apply to you in other group plans if you have more than a 63 day gap in health coverage, and will cause you to lose the

guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition if you do not exhaust COBRA coverage. You have a right to request special enrollment under certain plans that you are eligible for if you (a) apply within 30 days of coverage termination related to the initial qualifying event or (b) apply within 30 days of exhaustion of COBRA continuation coverage, If you reject COBRA coverage before the deadline for election, you may still elect COBRA before the election deadline by completing a new election form and your coverage will be effective on the date the form is received by the plan administrator or its designee.

PRIVACY INFORMATION

The Claims Administrator may release to, or obtain from any party, without consent of or notice to any person, any information the Plan Administrator or Claims Administrator deems necessary to carry out the provisions of the Plan. To the extent that this information is protected health information as described in 45 C.F.R. 164.500, *et seq.*, or other applicable law, the Plan Administrator or Claims Administrator may only use or disclose such information when related to treatment, payment or health care operations as allowed by such applicable law. Any claimant under the Plan shall furnish to the Claims Administrator such information as may be necessary to carry out this provision.

Only individuals, and their clerical support staff, who are involved with Plan administration, supervision or management, shall be given protected health information, and only to the extent necessary to perform duties assigned by the Plan Administrator. In addition, the Plan Sponsor hereby certifies and agrees that it will: (a) Not use or further disclose the information other than as permitted or required by the Plan or as required by law; (b) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan; (c) Ensure that any agents, including a subcontractor, to whom it provides protected health information received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;(d) Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor; (e)Report to the appropriate representative of the Plan Administrator any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware; (f) Make available protected health information in accordance with 45 C.F.R. 164.524; (g) Make available health information for amendment and incorporate any amendments to protected health information in accordance with 45 C.F.R. 164.526; (h) Make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. 164.528; (i)Make its internal practices, books, and records relating to the use and disclosure of protected health information received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the privacy requirements of 45 C.F.R. 164.500, *et seq.*; (j)If feasible, return or destroy all protected health information received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and (k) Ensure that the adequate separation between the Plan and the Plan Sponsor is established and maintained pursuant to 45 C.F.R. 164.504(f)(2)(iii) and is supported by reasonable and appropriate security measures.

The use of protected health information by the Plan shall be in accordance with the privacy rules established by 45 C.F.R. 164.500, *et seq*. Any issues of noncompliance with the provisions of this Section shall be resolved by the privacy officer of the Plan Administrator.

STATEMENT OF RIGHTS UNDER THE NEWBORN'S AND MOTHERS' HEALTH PROTECTION ACT

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital lengths of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification. For information on pre-certification, contact your plan administrator.

GRANDFATHER PROVISION

This group health plan believes it is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Act). As permitted by the Act, a grandfathered health plan can preserve coverage that was in effect when the law was enacted. Being a grandfathered plan means that your plan may not include certain consumer protections of the Act that applies to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered plans must comply with certain other consumer protections in the Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered plan and what might cause a plan to change from a grandfathered plan status can be directed to the Plan Administrator (Plan Sponsor, see page 2 of your Plan). Or you can contact the U.S. Department of Health and Human Services at www.healthreform.gov.